

## CERTIFICATE OF DEATH

09046

Reg. Dist. No.

9038

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>7/14/49</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>							
f. STREET ADDRESS <b>412 Furnace Street</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>A</b> Middle <b>Ira</b> Last <b>S. Anderson</b>				4. DATE OF DEATH Month <b>September</b> Day <b>5</b> Year <b>19 57</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/3/1892</b>					
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Barber</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Barber</b>							
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Marion Godfrey Anderson</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Shook</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>P. O. Box 599</b> Address <b>Cumberland, Md.</b>							
17. INFORMANT <b>Allegany County Infirmary Records</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Parkinsons Disease</b> <b>350x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intestinal Obstruction operating July 57</b> (c) <b>Operation - Colostomy Recurrence of Sept 4-57</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obstruction</b>				INTERVAL BETWEEN ONSET AND DEATH <b>?</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1/23/53</b> , 19____, to <b>9/5/57</b> , 19____, that I last saw the deceased alive on <b>9/5/57</b> , 19____, and that death occurred at <b>8:05P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>9/6/57</b>											
ACTUAL SIGNATURE <b>L. B. Mathews</b> M.D.				PHYSICIAN'S NAME (Type) <b>Dr. L. B. Mathews</b> <b>Cumberland, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)					
<b>Burial</b>		<b>Sept 9, 1957</b>		<b>Rose Hill Cem</b>		<b>Cumberland Md</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b> ADDRESS <b>Cumb. Md.</b>				24a. REC'D BY REGISTRAR <b>Sept 7, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron M.D.</b> <b>Acting Registrar</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mirrored and difficult to read.

BUREAU V. 3

SEP 10 1957

RECEIVED

9039

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>				c. LENGTH OF STAY IN 1b <b>7 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BABY BOY</b> Middle <b>BISHOP</b> Last <b>BISHOP</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>27</b> Year <b>57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 19, 1957</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR: Months <b>7</b> Days <b>7</b> Hours <b>57</b>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CUMBERLAND, MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES N. BISHOP</b>				14. MOTHER'S MAIDEN NAME <b>DAWN CATHERINE MICHAELS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diffuse purulent meningitis</b> <b>769.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Maternal endometritis (intrapartum)</b> DUE TO (c) <b>Maternal endometritis (intrapartum)</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>9/20</b> , 19 <b>57</b> , to <b>9/27</b> , 19 <b>57</b> ; that I last saw the deceased alive on <b>9/27</b> , 19 <b>57</b> , and that death occurred at <b>9:07 A.M.</b> , from the causes and on the date stated above. <b>W.R. Hodges</b> ADDRESS (Street, city or town, state) <b>Cumberland, Md</b> DATE SIGNED <b>9/28/57</b>							
ACTUAL SIGNATURE <b>W. ROYCE HODGES, M.D.</b>				M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9-29-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wellsburg Cemetery, Wellsburg, Pa.</b>	
22d. LOCATION (City, town, or county) (State) <b>Wellsburg, Pa.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey A. Zeigler, Hyndman, Pa.</b>				24a. RECEIVED BY REGISTRAR <b>Sept. 28, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Camery, M.D.</b> <b>Acting Registrar</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES	
JAMES H. HARRIS		Male		40		1917		Baltimore, Md.		Carpenter		Heart Disease		Baltimore, Md.		10:30 AM		J. H. Harris		J. H. Harris	
12. MARITAL STATUS		13. EDUCATION		14. RELIGION		15. COLOR		16. HEIGHT		17. WEIGHT		18. BUILD		19. COMPLEXION		20. HAIR		21. EYES		22. MOUTH	
Married		High School		Roman Catholic		White		5' 10"		170 lbs		Medium		Fair		Brown		Blue		Well	
23. PLACE OF INTERMENT		24. NAME OF CEMETERY		25. DATE OF INTERMENT		26. NAME OF MINISTER		27. NAME OF CHURCH		28. NAME OF FUNERAL HOME		29. NAME OF UNDERTAKER		30. NAME OF COFFIN		31. NAME OF CASKET		32. NAME OF CASKET		33. NAME OF CASKET	
St. Mary's Cemetery		St. Mary's Cemetery		10/10/57		Rev. J. H. Harris		St. Mary's Church		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

RECEIVED  
OCT 2 1957  
BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9082

CERTIFICATE OF DEATH

09048

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>			
c. LENGTH OF STAY IN 1b <b>50 yrs.</b>				d. STREET ADDRESS <b>45 Mill Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>45 Mill Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LEWIS</b> Middle <b>J.</b> Last <b>BITTNER</b>				4. DATE OF DEATH Month <b>9</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-22-1881</b>		9. AGE (In years last birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own business</b>		11. BIRTHPLACE (State or foreign country) <b>Somerset County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Bittner</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Ellen Shaeffer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Robert Bittner, 46 Standish St. Frostburg Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X Cerebral Hemorrhage</b> DUE TO (b) <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>several years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> , to <b>Sept 7, 1957</b> , that I last saw the deceased alive on <b>Sept 6, 1957</b> , and that death occurred at <b>3:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W O Mc Lane</b> M.D.				DATE SIGNED <b>Sept 9 1957</b>			
PHYSICIAN'S NAME (Type) <b>W O Mc Lane MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-9-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park, Frostburg Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Beverly H. Montecant</b> ADDRESS <b>Hafer Funeral Home 23 E. Main, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 9-9-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Nancy H. Rice</b>	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 11

BUREAU V. 3

SEP 16 1957

RECEIVED

9090

## CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b <b>50 Yrs.</b>				X2 <b>R. D. 1, Mt. Savage</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. D. 1, Mt. Savage</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>Melissa</b> Last <b>Brailer</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>15th</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 25th, 1883</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework home own</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Gibson</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Grant</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-10-1238</b>			
17. INFORMANT <b>John Brailer, R.D.1, Mt. Savage, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 5, 1956</b> , to <b>Sept. 15, 1957</b> , that I last saw the deceased alive on <b>Sept. 15, 1957</b> , and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Martin M. Rothstein</i> M.D. <b>48 Broadway</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>9/16/57</b>			
PHYSICIAN'S NAME (Type) <b>Martin M. Rothstein, M.D. 48 Broadway, Frostburg, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-18-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery, Mt. Savage, Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <i>Veronica M. Demmitt</i> per K M D	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1878		BALTIMORE, MD.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1905		BALTIMORE, MD.		JANE HARRIS		1915		BALTIMORE, MD.	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
LABORER		1910		BALTIMORE, MD.		BALTIMORE, MD.		1915		BALTIMORE, MD.	
CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		1915		BALTIMORE, MD.		J. H. HARRIS		1915		BALTIMORE, MD.	
MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
NATURAL		1915		BALTIMORE, MD.		J. H. HARRIS		1915		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
J. H. HARRIS		1915		BALTIMORE, MD.		J. H. HARRIS		1915		BALTIMORE, MD.	
SIGNATURE OF DECEASED		DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
J. H. HARRIS		1915		BALTIMORE, MD.		J. H. HARRIS		1915		BALTIMORE, MD.	

BUREAU V. S.

SEP 21 1917

RECEIVED



9040

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Reside. or of last admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> <del>HOEDOWN, CASH VALLEY RD., CUMBERLAND, MD.</del>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>				c. LENGTH OF STAY IN 1b <b>90</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>R.F.D. #1, Cash Valley Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>KARL H. BUTLER</b>				4. DATE OF DEATH Month Day Year <b>9-6-57 FRIDAY 1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-26-1880</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Architect</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>KENNEDY H. BUTLER</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>WIFE MARY M. BUTLER, SAME AS ABOVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 yrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Cumberland, Md.</b>				20g. (County) <b>Allegany</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>8-30</b> , 19 <b>57</b> , to <b>9-6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9-6-57</b> , 19 <b>57</b> , and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>105 S. Centre</b> DATE SIGNED <b>9-7-57</b>							
ACTUAL SIGNATURE <b>CC Zimmermann</b> M.D.				PHYSICIAN'S NAME (Type) <b>CC ZIMMERMANN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/10/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Right, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>Sept. 10, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b> <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09051
DR. W.F. WILLIAMS 9041										CERTIFICATE OF DEATH
1. PLACE OF DEATH										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. COUNTY ALLEGANY					b. COUNTY ALLEGANY					Reg. Dist. No. 4
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL					d. STREET ADDRESS 1 150 THOMAS STREET					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)										4. DATE OF DEATH
First MARY Middle WILHELMINA Last CLARK										Month SEPTEMBER Day 4 Year 1957
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 5, 1884		9. AGE (In years last birthday) 72 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse-				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE A. HADRA					14. MOTHER'S MAIDEN NAME ELIZABETH MUDGE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 212-24-0279		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Arteriosclerotic Vascular Dis. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1-1957 to 9-4-1957 that I last saw the deceased alive on 9-3-1957, and that death occurred at 5:27 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W.F. Williams M.D. Cumberland Md 9-4-57										
ACTUAL SIGNATURE DR. W.F. WILLIAMS					PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 9-7-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			22d. LOCATION (City, town, or county) (State) Cumberland, Md.		
23a. FUNERAL DIRECTOR'S SIGNATURE James F. Scapell, Cumberland, Md.					ADDRESS		24a. REC'D BY REGISTRAR Sept 7, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Carson, M.D. Acting Registrar	

548

BUREAU V. 3.

SEP 10 1957

RECEIVED

9091

## CERTIFICATE OF DEATH

Reg. Dist. No.

10

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Savage</b>				c. LENGTH OF STAY IN 1b <b>50 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>Margaret Ellen Conroy</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>30th</b> , Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 19th, 1876</b>	9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Timothy Conroy</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Logsdon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Matthew Campbell, Mt. Savage, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>25 yrs?</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/15/57</b> , 19 <b>57</b> , to <b>9/30</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9/30</b> , 19 <b>57</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>48 Broadway</b> DATE SIGNED <b>Veronica M. Smith</b>							
ACTUAL SIGNATURE <b>MARTIN M. ROTHSTEIN M.D. FROSTBURG - MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-3-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Patricks Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>Oct. 3/57</b>			
				24b. REGISTRAR'S SIGNATURE <b>Veronica M. Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		39		JAN 5 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
COUNSELOR		HIGH SCHOOL		MARRIED		METHODIST		WHITE		WHITE		BROWN		BLUE	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
APRIL 4 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		SHOOTING		SUICIDE		100-443886-100	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4 1968		APRIL 4 1968		APRIL 4 1968		APRIL 4 1968		APRIL 4 1968		APRIL 4 1968		APRIL 4 1968		APRIL 4 1968	

RECEIVED  
OCT 7 1967  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		9942		CERTIFICATE OF DEATH		89053	
DR. WEISMAN		Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIDGELEY 85X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>32 KNOBLEY STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM CAMBRIDGE CORNELIUS</b>		4. DATE OF DEATH Month Day Year <b>SEPTEMBER 20 19 57</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPTEMBER 22, 1870</b> 87 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CORNELIUS, WILLIAM M.</b>		14. MOTHER'S MAIDEN NAME <b>MRS Mary B. Taylor</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE INTRACEREBRAL HEMORRHAGE 7 HRS</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO <b>DISEASE</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 5 yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>SEP 20, 1957</b> , to <b>SEP 20, 1957</b> , that I last saw the deceased alive on <b>SEP 20, 1957</b> , and that death occurred at <b>10:25 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>59 Greene St Cumberland, Md</b>		DATE SIGNED <b>9/21/57</b>			
ACTUAL SIGNATURE <b>Dr. Weisman</b> M.D.							
PHYSICIAN'S NAME (Type) <b>DR. WEISMAN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>SEP 23-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenhill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Greenhill Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wayne C. Spiggle</b>		ADDRESS <b>Davis Union</b>		24a. REC'D BY REGISTRAR <b>SEP 23, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Rose Cameron, M.D. Acting Registrar</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09054

Reg. Dist. No. 4

9-43

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Mineral</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>13 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u> <span style="float: right;">85 X-3</span>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>at Memorial Hospital</u>				d. STREET ADDRESS <u>R.F.D. #1</u>			
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Hetzel</u> Last <u>Cupp</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>11</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24-1892</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>	IF UNDER 24 HRS. Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer-Storeroom</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. B&amp;O.R. Ry.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Geprge Cupp</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Day</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>W.W.1</u>		17. INFORMANT Address <u>(wife) Matilda Cupp, Ridgely, W. Va. Rt/#1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis</u> about <u>2 yrs.</u> (c) <u>    </u> DUE TO <u>    </u> causing the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>    </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>    </u> 19 <u>    </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept. 11-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 14, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mineral Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Fort Ashby, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc., Cumberland, Maryland.</u>				ADDRESS <u>Stein</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron M.D.</u> <u>Acting Registrar</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED

RECEIVED  
SEP 16 1957  
BUREAU V. S.



Within corporate limits DR. JACOBSON

9044

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> <b>ALLEGANY</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write rural or nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>56oney Run Road</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>DROLL</b> Last <b>DROLL</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>22</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1, 1883</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MINER - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mining</b>	
11. BIRTHPLACE (State or foreign country) <b>AUSTRIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>AMBROSE, DROLL</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE HINEPECK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>236-12-1094</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Various organisms</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema, silicosis?</b>			19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9/19/57</b> , 19____, to <b>9/22/57</b> , 19____, that I last saw the deceased alive on <b>9/22/57</b> , 19____, and that death occurred at <b>11:42 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>50 Pershing Street</b> DATE SIGNED <b>9/23/57</b>			
ACTUAL SIGNATURE <b>Samuel M. Jacobson</b> M.D.		Cumberland, Maryland	
PHYSICIAN'S NAME (Type) <b>Samuel M. Jacobson, M.D.</b>		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 25, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bloomington Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Bloomington, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Boal Funeral Home, Westernport, Maryland.</b>		24a. REC'D BY REGISTRAR <b>Sept. 25, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D. Acting Registrar</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

JACOBSON

<p>1. NAME OF DECEASED JACOBSON</p>		<p>2. SEX MALE</p>	
<p>3. AGE 34</p>		<p>4. DATE OF BIRTH JAN 15 1923</p>	
<p>5. PLACE OF BIRTH NEW YORK</p>		<p>6. OCCUPATION ENGINEER</p>	
<p>7. MARITAL STATUS MARRIED</p>		<p>8. DATE OF MARRIAGE JUN 15 1945</p>	
<p>9. NAME OF SPOUSE JACOBSON</p>		<p>10. DATE OF DEATH SEP 15 1957</p>	
<p>11. PLACE OF DEATH HOSPITAL</p>		<p>12. CAUSE OF DEATH HEART DISEASE</p>	
<p>13. SIGNATURE OF PHYSICIAN [Signature]</p>		<p>14. SIGNATURE OF REGISTRAR [Signature]</p>	

BUREAU V. 2

SEP 27 1957

RECEIVED

With corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09056

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Bedford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>State Line -near Ellerslie, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>at Memorial Hospital</u>		d. STREET ADDRESS <u>75X-3</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>McClullen</u> Last <u>Emerick</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>2</u> Year <u>1958-57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 19- 1910</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automatic control man-K-S.Tire Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ellerslie, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13. FATHER'S NAME <u>James E. Emerick</u>		14. MOTHER'S MAIDEN NAME <u>Anna M. Snowden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>196-10-0914</u>	
17. INFORMANT <u>Md. State Police, Cumberland, Md.</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-abdominal hemorrhage due to torn</u> DUE TO <u>blood vessels from a crushed &amp; dislocated</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3rd. lumber vertebrae, due to being crushed</u> DUE TO <u>between two jeeps.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <u>Standing in front of Jeep painting it, in Corriganville</u>		20b. DESCRIBE HOW INJURY OCCURRED (Brief nature of injury as Part V of Part II of form) <u>Time Dept. another man drove a jeep in, caught between.</u>	
20c. TIME OF INJURY Month, Day, Year <u>2.45 p.m. Sept. 2 1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, or other street or place) <u>Corriganville, Allegany, Md.</u>	20f. (City or town) (County) (State) <u>Corriganville, Allegany, Md.</u>

21. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>Sept. 2-1957</u>
EXAMINER'S NAME (Type) <u>H.V. Deming, M.D.</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 5, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Ellerslie, Maryland (rural)</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Zeigler, Hyndman, Pennsylvania.</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u>	
ADDRESS <u>374</u>		24a. REC'D BY REGISTRAR <u>Sept. 4, 1957</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
SEP 5 1957  
BUREAU V. S.

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Within corporate limits				MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				09057			
DR. WEISMAN 9046				CERTIFICATE OF DEATH				Reg. Dist. No. 4			
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>11 DAYS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>113 S. SMALLWOOD STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CURTISS GLENN ESHELMAN</b>				4. DATE OF DEATH Month Day Year <b>SEPTEMBER 22 19 57</b>							
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 26, 1905</b>		9. AGE (In years last birthday) yrs. <b>52</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERVISOR</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>KELLY SPR. TIRE CO. EVERETT, PA.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>GEORGE ESHELMAN</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET ESHELMAN</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO. <b>214-07-0012</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>2040</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Lymphoblastic Leukemia</b> DUE TO (c) <b>2 mos</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <b>19 56</b> to <b>Sept 22, 19 57</b> that I last saw the deceased alive on <b>Sept 21, 19 57</b> , and that death occurred at <b>1:35 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>59 Greene St</b> DATE SIGNED <b>9/22/57</b>											
ACTUAL SIGNATURE <b>S.G. Weisman</b> M.D.				PHYSICIAN'S NAME (Type) <b>DR. S.G. WEISMAN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Everett Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Everett, Penna.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b> ADDRESS <b>Cumberland, Md.</b>						24a. REC'D BY REGISTRAR <b>Sept 25, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D. Acting Registrar</b>			



CERTIFICATE OF DEATH

DR. MEDICAL

ALLERGY

MARYLAND

DATE AND

ALLERGY

CUMBERLAND

1 DAY

CUMBERLAND

MEMORIAL HOSPITAL

112 S. BALTIMORE STREET

BERNARD

ESHELBAUM

LEWIS

CHRISTIAN

MADE BY

WHITE

WHITE

WHITE

MARYLAND ESHELBAUM

GEORGE ESHELBAUM

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

BUREAU V. S.

SEP 04 1957

RECEIVED

DR. S. A. WEISMAN

WEISMAN

## CERTIFICATE OF DEATH

09058

Reg. Dist. No.

9047

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>1 DAY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>1725 FREDERICK ST.</b>			
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>Thomas</b> Last <b>FOST</b>				4. DATE OF DEATH Month <b>SEPTEMBER 9,</b> Day <b>19</b> Year <b>57</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 28, 1874</b>	9. AGE (In years last birthday) <b>83</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farm owner</b>		11. BIRTHPLACE (State or foreign country) <b>FULTON CO. PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>FOST, HENRY</b>				14. MOTHER'S MAIDEN NAME <b>SOUDERS, MARGARET</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>420.1</b> DUE TO <b>Acute Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> (c) <b>Coronary Sclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 days</b> <b>2 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sep 8, 1957</b> to <b>Sep 9, 1957</b> that I last saw the deceased alive on <b>Sep 9, 1957</b> and that death occurred at <b>6:50 P.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. G. Weisman</b>				M.D. <b>59 Greene St</b>		DATE SIGNED <b>9/10/57</b>	
PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>				<b>Cumberland, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/12/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Presbyterian Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Warfordsburg, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>Sep 12, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b>		<b>Acting Registrar</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARY AND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. 21

SEP 16 1957

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SEP 16 1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09059

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## 9083 CERTIFICATE OF DEATH

Item 3 Film G220 9-20-57 et

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Allegany</b>		MARYLAND		STATE <b>Md</b>		COUNTY <b>Allegany</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Westernport</b>				TOWN <b>Westernport</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>Vine St</b>				<b>Vine St,</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Amanda</b> (Middle) <b>E. Frankland</b> (Last)				(Month) <b>Sept.</b> (Day) <b>13</b> (Year) <b>19 57</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Female</b>	<b>White</b>	<b>Widowed</b>	<b>Oct. 5, 1887</b>	<b>82</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>House-wife</b>		<b>own home</b>		<b>Penna.</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Issac Fausnaught</b>				<b>Rebecca J. Reed</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<b>Rollin Frankland, Westernport Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A)				<b>Cerebral Hemorrhage</b>			
ANTECEDENT CAUSE(S) DUE TO				<b>Arterio-sclerosis</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<b>5 Days</b>			
				<b>5 Years</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<b>None</b>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
				<b>None</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Sept 8, 1957</b> , to <b>Sept 13, 1957</b> , that I last saw the deceased alive on <b>Sept 12, 1957</b> , and that death occurred at <b>6:40 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Paul B. Wilson</b>				ADDRESS (Street, city, town, state) <b>Ashfield St. Piedmont, W. Va</b>			
				DATE SIGNED <b>9/14/57</b>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>9/15/57</b>		<b>Philos Cemetery</b>		<b>Westernport, Md.</b>	
24. RECEIVED BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<b>SEP 17 1957</b>		<b>Jan C. Kelly</b>		<b>W. N. Fredlock Jr.</b>		<b>Piedmont, W. Va.</b>	
DATE							

# CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth

4. Place of birth

5. Usual residence

6. Cause of death

7. Date of death

8. Place of death

9. Signature of physician

10. Signature of registrar

11. Date of registration

12. Signature of informant

13. Address of informant

14. Signature of medical examiner

15. Address of medical examiner

16. Signature of coroner

BUREAU V. 8

SEP 17 1957

RECEIVED



Within corporate limits

9048

CERTIFICATE OF DEATH

09060

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. VA.</b> b. COUNTY <b>HARDY.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MOOREFIELD</b> 85x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES H. FRIDDLE</b>		4. DATE OF DEATH Month Day Year <b>SEPTEMBER 10 1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 11, 1885</b>
9. AGE (In years last birthday) <b>72 1/2</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CLINE'S APPLIANCE CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>South Saxton, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>HENRY FRIDDLE - DEC.</b>		14. MOTHER'S MAIDEN NAME <b>ELLA FLETCHER - DEC.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>232-26-0026</b>	
17. INFORMANT <b>Charles H. Friddle, Jr., Moorefield, W. Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia, acute</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9 Sept 1957</b> , to <b>10 Sept 1957</b> , that I last saw the deceased alive on <b>10 Sept 1957</b> , and that death occurred at <b>5:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>W. Alfred Van Ormer</b> M.D. <b>10 Sept 1957</b>			
ACTUAL SIGNATURE <b>W. Alfred Van Ormer</b>			
PHYSICIAN'S NAME (Type) <b>DR. WM. VAN ORMER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>9-12-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Shelton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Moorefield W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Friddle, Jr.</b>		ADDRESS <b>Moorefield W. Va.</b>	
24a. REG'D BY REGISTRAR <b>11, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Rose Cameron, M.D.</b> <b>Acting Registrar</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 13 1957

RECEIVED

CERTIFICATE OF DEATH

MAKING STATE DEPARTMENT OF HEALTH - BUREAU ONE 18

HOSPITAL

CHARGE

22-2-202

## 9084 CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport, Md.</b>				c. LENGTH OF STAY IN 1b <b>35 Yrs</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b> <b>43</b>				d. STREET ADDRESS <b>Raridan Rd.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Raridan Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Gardine</b> Last <b>Gardine</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>30,</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 April 1895</b>	9. AGE (In years lost birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truckman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O. R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
13. FATHER'S NAME <b>not known</b>				14. MOTHER'S MAIDEN NAME <b>not known</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W. I</b>				16. SOCIAL SECURITY NO. <b>213-16-9956</b>		17. INFORMANT <b>Mrs. Joseph Gardine-Westernport, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease,</b> <b>420.1</b> DUE TO Hypertensive Cardio Renal disease, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>5yrs</b> (c)							INTERVAL BETWEEN ONSET AND DEATH <b>5mo</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>Piedmont W Va</b>		(County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>57</b> , to <b>Sep 30,</b> 19 <b>57</b> , that I last saw the deceased alive on <b>Sep 28th 1957</b> , and that death occurred at <b>3.30a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Piedmont W Va</b> DATE SIGNED <b>10/1/57</b>							
ACTUAL SIGNATURE <b>James H Wolverson Sr</b> M.D.				PHYSICIAN'S NAME (Type) <b>James H Wolverson Sr Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 4, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Boral</b>				ADDRESS <b>Westernport, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>10-3-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>James C. Kelly</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 4 1957

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9085

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			c. LENGTH OF STAY IN 1b <u>16 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>319 E. Main St.</u>				d. STREET ADDRESS <u>319 E. Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Robert</u> Last <u>Glofelty</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>30</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27-1902</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mine Foreman- Consolidated Coal Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Consolidated Coal Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Wittsburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George Glofelty</u>				14. MOTHER'S MAIDEN NAME <u>Alverta Lancaster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-01-3574</u>		17. INFORMANT Address <u>(daughter) Mrs. Thomas Blair, Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>5230</u> DUE TO <u>Hypostasis of lungs also had</u> Conditions, if any, which gave rise to immediate cause (b) <u>Silicosis.</u> (c) <u>about</u> DUE TO <u>5 yrs.</u> cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>Gradual</u> <u>a few days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept. 30-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-2-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Hurst</u>				24a. REC'D BY REGISTRAR <u>DATE 10-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. Nancy H. Reg</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
OCT 11 1957  
BUREAU V. 3

9049

CERTIFICATE OF DEATH

09062

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>	
c. LENGTH OF STAY IN TB <b>9/11/57</b>		d. STREET ADDRESS <b>2 Castle Hill</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>Marie</b> Last <b>Gowans</b>		4. DATE OF DEATH Month <b>September</b> Day <b>28</b> , Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13, 1920</b>
9. AGE (In years last birthday) <b>37</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None - Handicapped</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Alexander Gowans</b>		14. MOTHER'S MAIDEN NAME <b>Annie Martha Ritchey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, Unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>P.O. Box 599</b> Address <b>Cumberland, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial degeneration,</b> DUE TO <b>Pulmonary Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Hypertension</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/11/57</b> , 19 <b>57</b> , to <b>9/28/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9/28/57</b> , 19 <b>57</b> , and that death occurred at <b>11:24 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>9/29/57</b>			
ACTUAL SIGNATURE <b>Dr. L. B. Mathews</b> M.D.		DATE SIGNED <b>9/29/57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/1/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Eastburg Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b> ADDRESS <b>Lonaconing, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct. 2, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron M.D. Acting Registrar</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 10

TABLE 1

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12. 0000, 0000, 0000

U. S. Navy ; unclassified

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• J. J. O'NEILL, Ed.

(Ct. D. - Matthews - 70)

No. 69

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Within corporate limits

9050

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegheny</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>02 Cumberland</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>218 Pear St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegheny</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <b>1218 Pear St</b>			
3. NAME OF DECEASED (Type or print) <b>Nellie</b>		First <b>Augusta</b>		Middle <b>Grain</b>		Last <b>Sept.</b>		4. DATE OF DEATH Month <b>19</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 3, 1902</b>		9. AGE (In years last birthday) <b>55</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Law Office</b>		11. BIRTHPLACE (State or foreign country) <b>Haysville, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Thomas Benton Clawson</b>		14. MOTHER'S MAIDEN NAME <b>Mary McCreary</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <b>Charles E. Grain, Cumberland, Md.</b>		17. INFORMANT Address <b>218 Pear St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic Heart Disease</b> DUE TO (c) <b>none</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 da.</b> <b>40 yrs</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>none</b>		20g. (County) <b>none</b>		20h. (State) <b>none</b>		20i. (City or town) <b>none</b>		20j. (County) <b>none</b>	
20k. (State) <b>none</b>		20l. (City or town) <b>none</b>		20m. (County) <b>none</b>		20n. (State) <b>none</b>		20o. (City or town) <b>none</b>	
20p. (County) <b>none</b>		20q. (State) <b>none</b>		20r. (City or town) <b>none</b>		20s. (County) <b>none</b>		20t. (State) <b>none</b>	
20u. (City or town) <b>none</b>		20v. (County) <b>none</b>		20w. (State) <b>none</b>		20x. (City or town) <b>none</b>		20y. (County) <b>none</b>	
20z. (State) <b>none</b>		20aa. (City or town) <b>none</b>		20ab. (County) <b>none</b>		20ac. (State) <b>none</b>		20ad. (City or town) <b>none</b>	
20ae. (County) <b>none</b>		20af. (State) <b>none</b>		20ag. (City or town) <b>none</b>		20ah. (County) <b>none</b>		20ai. (State) <b>none</b>	
20aj. (City or town) <b>none</b>		20ak. (County) <b>none</b>		20al. (State) <b>none</b>		20am. (City or town) <b>none</b>		20an. (County) <b>none</b>	
20ao. (State) <b>none</b>		20ap. (City or town) <b>none</b>		20aq. (County) <b>none</b>		20ar. (State) <b>none</b>		20as. (City or town) <b>none</b>	
20at. (County) <b>none</b>		20au. (State) <b>none</b>		20av. (City or town) <b>none</b>		20aw. (County) <b>none</b>		20ax. (State) <b>none</b>	
20ay. (City or town) <b>none</b>		20az. (County) <b>none</b>		20ba. (State) <b>none</b>		20bb. (City or town) <b>none</b>		20bc. (County) <b>none</b>	
20bd. (State) <b>none</b>		20be. (City or town) <b>none</b>		20bf. (County) <b>none</b>		20bg. (State) <b>none</b>		20bh. (City or town) <b>none</b>	
20bi. (County) <b>none</b>		20bj. (State) <b>none</b>		20bk. (City or town) <b>none</b>		20bl. (County) <b>none</b>		20bm. (State) <b>none</b>	
20bn. (City or town) <b>none</b>		20bo. (County) <b>none</b>		20bp. (State) <b>none</b>		20bq. (City or town) <b>none</b>		20br. (County) <b>none</b>	
20bs. (State) <b>none</b>		20bt. (City or town) <b>none</b>		20bu. (County) <b>none</b>		20bv. (State) <b>none</b>		20bw. (City or town) <b>none</b>	
20bx. (County) <b>none</b>		20by. (State) <b>none</b>		20bz. (City or town) <b>none</b>		20ca. (County) <b>none</b>		20cb. (State) <b>none</b>	
20cc. (City or town) <b>none</b>		20cd. (County) <b>none</b>		20ce. (State) <b>none</b>		20cf. (City or town) <b>none</b>		20cg. (County) <b>none</b>	
20ch. (State) <b>none</b>		20ci. (City or town) <b>none</b>		20cj. (County) <b>none</b>		20ck. (State) <b>none</b>		20cl. (City or town) <b>none</b>	
20cm. (County) <b>none</b>		20cn. (State) <b>none</b>		20co. (City or town) <b>none</b>		20cp. (County) <b>none</b>		20cq. (State) <b>none</b>	
20cr. (City or town) <b>none</b>		20cs. (County) <b>none</b>		20ct. (State) <b>none</b>		20cu. (City or town) <b>none</b>		20cv. (County) <b>none</b>	
20cw. (State) <b>none</b>		20cx. (City or town) <b>none</b>		20cy. (County) <b>none</b>		20cz. (State) <b>none</b>		20da. (City or town) <b>none</b>	
20db. (County) <b>none</b>		20dc. (State) <b>none</b>		20dd. (City or town) <b>none</b>		20de. (County) <b>none</b>		20df. (State) <b>none</b>	
20dg. (City or town) <b>none</b>		20dh. (County) <b>none</b>		20di. (State) <b>none</b>		20dj. (City or town) <b>none</b>		20dk. (County) <b>none</b>	
20dl. (State) <b>none</b>		20dm. (City or town) <b>none</b>		20dn. (County) <b>none</b>		20do. (State) <b>none</b>		20dp. (City or town) <b>none</b>	
20dq. (County) <b>none</b>		20dr. (State) <b>none</b>		20ds. (City or town) <b>none</b>		20dt. (County) <b>none</b>		20du. (State) <b>none</b>	
20dv. (City or town) <b>none</b>		20dw. (County) <b>none</b>		20dx. (State) <b>none</b>		20dy. (City or town) <b>none</b>		20dz. (County) <b>none</b>	
20ea. (State) <b>none</b>		20eb. (City or town) <b>none</b>		20ec. (County) <b>none</b>		20ed. (State) <b>none</b>		20ee. (City or town) <b>none</b>	
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20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>	
20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>	
20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>	
20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>	
20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>	
20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>	
20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>	
20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>	
20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>	
20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>	
20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>	
20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>	
20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>	
20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>	
20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>	
20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>	
20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>	
20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>	
20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>	
20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>	
20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>	
20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>	
20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>	
20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>	
20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>		20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>	
20ef. (State) <b>none</b>		20ef. (City or town) <b>none</b>		20ef. (County) <b>none</b>					

CERTIFICATE OF DEATH

See form 114

RECEIVED  
SEP 23 1957  
BUREAU V. S.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9086

CERTIFICATE OF DEATH

09064

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			
c. LENGTH OF STAY IN 1b <b>10 hrs.</b>				d. STREET ADDRESS <b>150 E. Main Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Hugh</b> First <b>A. Hotchkiss</b> Middle Last				4. DATE OF DEATH Month <b>9</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-9-1884</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>County Employee</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Md.</b>	
13. FATHER'S NAME <b>James Hotchkiss</b>				14. MOTHER'S MAIDEN NAME <b>Marian Atkinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-I4-7972</b>			
17. INFORMANT <b>Mrs. Hugh A. Hotchkiss</b>				Address <b>Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Low intestinal Obstruction</b> <b>153X</b> DUE TO <b>Probably due to Malignancy Lower Colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Colon</b> (c) <b>Colon</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept 15, 1957</b> to <b>Sept 16, 1957</b> , that I last saw the deceased alive on <b>Sept 15, 1957</b> , and that death occurred at <b>7:00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>WOM Lane</b> M.D.				ADDRESS (Street, city or town, state) <b>Frostburg Md.</b>			
PHYSICIAN'S NAME (Type) <b>WOM Lane</b>				DATE SIGNED <b>Sept 20 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-20-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park Frostburg Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pearl H. Mattingly Frostburg, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 9-20-57</b>			
				24b. REGISTRAR'S SIGNATURE <b>Mrs. Nancy N. Roe</b>			

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

9051

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Dawson</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS <b>/Rt. #38 Keyser, W.Va.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Ellen</b> Last <b>House</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>2</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 19-1882</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Myersdale, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Hersh</b>				14. MOTHER'S MAIDEN NAME <b>R ebecca Bear</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Memorial Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>Coronary osteal sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Cardiac hypertrophy</b> <b>Cerebral arteriosclerosis (marked)</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Budden</b>  <b>gradual</b>  <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H. V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept 2-1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 4, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dawson Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Dawson, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rogers Funeral Home, Keyser, West Virginia.</b>				24. REC'D BY REGISTRAR <b>Sept 3, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron M.D. Acting Registrar</b>	

Within corporate limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

SEP 4 1957

RECEIVED

Outside of  
City Limits

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9092

## CERTIFICATE OF DEATH

09067

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. # 2 Cumberland,</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Hillcrest Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>SUSAN</b> Last <b>HUFF</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>21,</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1871</b>
9. AGE (In years last birthday) <b>86 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Gerstell, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Levi Baker</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Kight</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>220-10-7603</b>	
17. INFORMANT <b>Mrs. Carl T. Cookerly Hillcrest Drive, Cumb. Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the rectum</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>154X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-25</b> , 19 <b>57</b> , to <b>9-21</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9-18</b> , 19 <b>57</b> , and that death occurred at <b>12:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 Greene St.,</b> DATE SIGNED ACTUAL SIGNATURE <b>L. Brings</b> M.D. <b>Lewis Brings M. D.</b> <b>Cumberland, Md.</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/24/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Biertown Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rawlings, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 24, 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b> <b>Acting Registrar</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

STATE OF NEW YORK

BUREAU V. 3

SEP 25 1957

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09066

Within corporate limits

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

9052

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>PENNA</u>		COUNTY <u>Bedford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CUMBERLAND</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hyndman</u>		<u>75x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>George Clay Hughes</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 14 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>OCT. 18, 1888</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAR INSPECTOR B &amp; O RAILROAD PENNSYLVANIA</u>			11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>William Hughes</u>				14. MOTHER'S MAIDEN NAME <u>LANNAH MARTZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-03-6317</u>		17. INFORMANT & ADDRESS <u>Mrs. Hilda Stuby Hyndman</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Chronic Arterio Sclerotic Cardio-Vascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>at work</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1956</u> , to <u>Sept 14, 1957</u> , that I last saw the deceased alive on <u>Sept 14, 1957</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John A. Topper</u> M.D.				ADDRESS (Street, city, town, state) <u>Hyndman Pa</u>		DATE SIGNED <u>9/15/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Sept. 17, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Hyndman Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hyndman, Pa</u>	
24. REC'D BY REGISTRAR <u>Sept. 16, 1957</u>		REGISTRAR'S SIGNATURE <u>W. Ross Cameron, Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey L. Zeigler</u>		ADDRESS <u>Hyndman</u>	

Acting Registrar

# CERTIFICATE OF DEATH

NAME OF DECEASED  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 OCCUPATION  
 MARITAL STATUS  
 COLOR OF SKIN  
 HIGHEST GRADE OF SCHOOL  
 RELIGION  
 RACE  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 OCCUPATION  
 MARITAL STATUS  
 COLOR OF SKIN  
 HIGHEST GRADE OF SCHOOL  
 RELIGION  
 RACE

DATE OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH  
 MANNER OF DEATH  
 MEDICAL ATTENDANCE  
 BURIAL PLACE  
 NAME OF FUNERAL HOME  
 NAME OF MINISTER  
 NAME OF CLERGYMAN  
 NAME OF CHAPLAIN  
 NAME OF RABBI  
 NAME OF PRIEST  
 NAME OF MINISTER  
 NAME OF CLERGYMAN  
 NAME OF CHAPLAIN  
 NAME OF RABBI  
 NAME OF PRIEST

NAME OF DECEASED  
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 DATE OF BIRTH  
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 MARITAL STATUS  
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 HIGHEST GRADE OF SCHOOL  
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 RACE

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 NAME OF PRIEST

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NAME OF DECEASED  
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 NAME OF PRIEST

NAME OF DECEASED  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 OCCUPATION  
 MARITAL STATUS  
 COLOR OF SKIN  
 HIGHEST GRADE OF SCHOOL  
 RELIGION  
 RACE

DATE OF DEATH  
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 MEDICAL ATTENDANCE  
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 NAME OF FUNERAL HOME  
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 NAME OF CHAPLAIN  
 NAME OF RABBI  
 NAME OF PRIEST

NAME OF DECEASED  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 OCCUPATION  
 MARITAL STATUS  
 COLOR OF SKIN  
 HIGHEST GRADE OF SCHOOL  
 RELIGION  
 RACE

DATE OF DEATH  
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 MANNER OF DEATH  
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 NAME OF CLERGYMAN  
 NAME OF CHAPLAIN  
 NAME OF RABBI  
 NAME OF PRIEST

NAME OF DECEASED  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 OCCUPATION  
 MARITAL STATUS  
 COLOR OF SKIN  
 HIGHEST GRADE OF SCHOOL  
 RELIGION  
 RACE

DATE OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH  
 MANNER OF DEATH  
 MEDICAL ATTENDANCE  
 BURIAL PLACE  
 NAME OF FUNERAL HOME  
 NAME OF MINISTER  
 NAME OF CLERGYMAN  
 NAME OF CHAPLAIN  
 NAME OF RABBI  
 NAME OF PRIEST

RECEIVED  
 SEP 18 1957  
 BUREAU V. S.

RECEIVED

CERTIFICATE OF DEATH

09068

Reg. Dist. No.

9053

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE W. JOHNSON</b>				4. DATE OF DEATH Month Day Year <b>SEPTEMBER 22, 1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 18, 1897</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		11. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. AM.</b>	
13. FATHER'S NAME <b>JOHNSON, AUGUST S.</b>				14. MOTHER'S MAIDEN NAME <b>Althemia Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214 07 5714H</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA</b> 199.9 DUE TO <b>Intestinal obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Intestinal obstruction</b> DUE TO (c) <b>Intestinal obstruction</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs 3 weeks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 19, 1957</b> , to <b>Sept 22, 1957</b> , that I last saw the deceased alive on <b>Sept 22, 1957</b> , and that death occurred at <b>7:40P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>128 Union St Cumberland Md</b> DATE SIGNED <b>9/23/57</b>							
ACTUAL SIGNATURE <b>Dr. George M. Simons</b>		M.D. <b>128 Union St Cumberland Md</b>					
PHYSICIAN'S NAME (Type) <b>DR. GEORGE SIMONS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 25, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Knight, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>Sept. 23, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D. Acting Registrar</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		RELIGION	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		COMPLICATIONS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	

**RECEIVED**  
SEP 25 1957  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09069

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

9054

Within corporate limits

1. PLACE OF DEATH  
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

8 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

02 Cumberland

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

at Memorial Hospital

d. STREET ADDRESS

124 Blackiston Ave.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED  
(Type or print)

First Derl

Middle Alexander

Last Keller

4. DATE OF DEATH

Month Sept.

Day 13

Year 19 57

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Dec. 30-1915

9. AGE (In years last birthday)

41 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machinest

10b. KIND OF BUSINESS OR INDUSTRY

B&O.R.Ry.

11. BIRTHPLACE (State or foreign country)

Alexander, W.Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

LeRoy Keller

14. MOTHER'S MAIDEN NAME

Katie Barger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

(wife) Virginia Henry, Cumberland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

sudden

420.1

DUE TO

Coronary sclerosis

?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Artherous sclerosis

?

DUE TO

Cardiac hypertrophy

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour o. m. p. m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE

H.V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

H.V. Deming M.D.

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒ Sept. 14-1957

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

9-16-57

22c. NAME OF CEMETERY OR CREMATORY

Hillcrest Burial Park

22d. LOCATION (City, town, or county)

Cumberland, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

James F. Scarpelli

ADDRESS

Cumberland, Md.

24a. REC'D BY REGISTRAR

DATE Sept 16, 1957

24b. REGISTRAR'S SIGNATURE

W. Ross Cameron M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5

SEP 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

Within corporate limits  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09070

Reg. Dist. No. 4

9055

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>WEST VIRGINIA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELK GARDEN</b> <b>85x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL &amp; WARWICK AVES.,</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>KITZMILLER</b> Middle <b>KITZMILLER</b> Last <b>KITZMILLER</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>17</b> Year <b>1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 17, 1957</b>
9. AGE (In years last birthday) yrs. <b>25</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JACK W. KITZMILLER</b>		14. MOTHER'S MAIDEN NAME <b>JOAN MARKER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>776x</b>	
17. INFORMANT <b>Fuller B. Whitworth</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity 24-26 wks</b> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-17-</b> <b>1957</b> , to <b>9-18-</b> <b>1957</b> , that I last saw the deceased alive on <b>9-17-57</b> , <b>19</b> , and that death occurred at <b>10:29 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>FULLER B. WHITWORTH</b>		DATE SIGNED <b>18 Sept</b>	
PHYSICIAN'S NAME (Type) <b>Fuller B. Whitworth</b>		ADDRESS (Street, city or town, state) <b>123 Bedford St.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>Sept. 18, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Memorial Hospital, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>W. Ross Cameron Jr.</b>	
ADDRESS <b>Memorial Hospital, Cumberland, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Acting Registrar</b>	

2060211XVI

CERTIFICATE OF DEATH

Form 10-1-57

NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH JAN 5 1928	PLACE OF BIRTH MOBILE, ALA.
SEX MALE		DATE OF DEATH JUN 4 1968	PLACE OF DEATH MEMPHIS, TENN.
OCCUPATION ATTORNEY		CAUSE OF DEATH HEART DISEASE	MANNER OF DEATH NATURAL
EDUCATION HIGH SCHOOL		DATE OF BURIAL JUN 6 1968	PLACE OF BURIAL MEMPHIS, TENN.
RELIGION METHODIST		DATE OF INTERMENT JUN 6 1968	PLACE OF INTERMENT MEMPHIS, TENN.
MARRIAGE MARRIED		DATE OF MARRIAGE JUN 19 1953	PLACE OF MARRIAGE MEMPHIS, TENN.
SPOUSE JANE P. RAY		DATE OF SPOUSE'S DEATH JUN 19 1953	PLACE OF SPOUSE'S DEATH MEMPHIS, TENN.
CHILDREN JAMES EARL RAY JR.		DATE OF CHILD'S BIRTH JUN 19 1953	PLACE OF CHILD'S BIRTH MEMPHIS, TENN.
SIGNED BY JAMES EARL RAY		DATE JUN 4 1968	PLACE MEMPHIS, TENN.
WITNESSES JANE P. RAY		DATE JUN 4 1968	PLACE MEMPHIS, TENN.
DOCTOR JAMES EARL RAY		DATE JUN 4 1968	PLACE MEMPHIS, TENN.
CITY MEMPHIS		COUNTY SHELBY	STATE MISSISSIPPI

BUREAU IV-13 5

SEP 20 1967

RECEIVED

9056

## CERTIFICATE OF DEATH

09071

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL- MEMORIAL AVE.,</b>				d. STREET ADDRESS <b>415 1/2 HOLLAND ST.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>ALBERT</b> Last <b>KNIERIEM</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>3</b> Year <b>19 57.</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DECEMBER 6, 1927</b>	
9. AGE (In years lost birthday) <b>29</b> yrs.		IF UNDER 1 YEAR Months <b>29</b> Days <b>29</b> Hours <b>29</b> Min.		IF UNDER 24 HRS. Months <b>29</b> Days <b>29</b> Hours <b>29</b> Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm employee</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>JOHN P. KNIERIEM</b>				14. MOTHER'S MAIDEN NAME <b>LYDIA ARNOLD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-30-2331</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Tumor-Pleomorphic-Ependynoma</b> <b>193X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Surgery performed at Johns Hopkins Hospital-December 1956</b> INTERVAL BETWEEN ONSET AND DEATH <b>9 months ?</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>December</b> , 19 <b>56</b> , to <b>September 3</b> 19 <b>57</b> , that I last saw the deceased alive on <b>September 2</b> , 19 <b>57</b> , and that death occurred at <b>8:35 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>50 Pershing Street</b> DATE SIGNED <b>9/4/57</b>							
ACTUAL SIGNATURE <b>DR. SAMUEL JACOBSON</b> M.D. <b>Cumberland, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>Sept. 6, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>Sept. 5, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b> <b>Acting Registrar</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DATE OF DEATH

PLACE OF DEATH

DECEASED

AGE

SEX

HOSPITAL - NAME AND ADDRESS

DATE

TIME

CAUSE

DIAGNOSIS

ATTENDING PHYSICIAN

REPORTING PHYSICIAN

DATE

TIME

DATE

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CAUSE

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TIME

BUREAU V. 4

SEP 6 1957

RECEIVED

9057

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>				c. LENGTH OF STAY IN 1b <b>60yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>800 Schriver Ave.</b>				d. STREET ADDRESS <b>800 Schriver Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Lucius</b> Middle <b>C.</b> Last <b>Lang</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>I,</b> Year <b>1957</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 8, 1879</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Locomotive Engineer Railroad Newburg, W.Va.</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Geo. W. Lang</b>				14. MOTHER'S MAIDEN NAME <b>Susan Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Augusta Lang 800 Schriver Ave.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterial Hypertension</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>3 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 1st, 1957</b> , to <b>Sept 1, 1957</b> , that I last saw the deceased alive on <b>Aug 31, 1957</b> , and that death occurred at <b>6 P. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. W. Trevasakis, Jr</b>				DATE SIGNED <b>9/1/57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. R. W. Trevasakis</b>				ADDRESS (Street, city or town, state) <b>210 Baltimore Ave Cumberland, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-4-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				24. REG'D BY REGISTRAR <b>W. Ross Cameron, M.D.</b>			
ADDRESS <b>Cumberland, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Acting Registrar</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BUREAU V. 1

SEP 5 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09073

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

9958

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>28 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Cumberland X/</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>R.F.D.#5 Potomac Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>McClenning</u> Last <u>Lewis</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>5</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 3-1898</u>		9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor-Installing</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>Morefield, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Jacob Lewis</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Howdershell</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>214-07-2977</u>				17. INFORMANT <u>(wife) Bertha Lewis, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis</u> (c) <u>  </u> DUE TO (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>Sept 5-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 7, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc., Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>Sept. 6, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Rose Cameron M.D.</u> <u>Acting Registrar</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 9 1965

RECEIVED



9087

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			
c. LENGTH OF STAY IN 1b <b>40 yrs.</b>				d. STREET ADDRESS <b>104 W. College Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>104 W. College Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CORA</b> Middle <b>FRANCES</b> Last <b>LIBENGOOD</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>18,</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1899</b>	9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sewer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garment factory</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lawrence Beal</b>				14. MOTHER'S MAIDEN NAME <b>Mollie Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-03-5411</b>		17. INFORMANT <b>Melvin E. Libengood, Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ascites, Emaciation, Dehydration</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of rt. breast with metastases</b> DUE TO (c) <b>metastases</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 wks.</b> <b>2 or 3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 17, 1957</b> , to <b>Sept 18, 1957</b> , that I last saw the deceased alive on <b>18 Sept 1957</b> , and that death occurred at <b>8 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ryple R. Eubank</b>				ADDRESS (Street, city or town, state) <b>125 N. H. Hwy Co Vale</b>			
PHYSICIAN'S NAME (Type) <b>Cumberland Md.</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-20-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst,</b>				ADDRESS <b>Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>9-20-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mrs. Nancy H. Rose</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

## CERTIFICATE OF DEATH

DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE		PLACE OF BIRTH STATE OF MARYLAND COUNTY OF BALTIMORE CITY OF BALTIMORE DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE	
DATE OF DEATH SEP 23 1957 TIME OF DEATH 10:00 AM PLACE OF DEATH BALTIMORE, MD DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE		CAUSE OF DEATH HEART DISEASE DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE	
SEX MALE AGE 65 OCCUPATION RETIRED DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE		MARITAL STATUS SINGLE DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE	
SIGNATURE OF DECEASED DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE		SIGNATURE OF WITNESS DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE DECEASED NAME LAST FIRST MIDDLE	

BUREAU V. 8

SEP 23 1957

RECEIVED

09075

DR. R.J. WILLIAMS 9059 CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
c. LENGTH OF STAY IN 1b <b>1 DAY</b>		d. STREET ADDRESS <b>1 215 CECILIA STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BRIDGET</b> Middle <b>R.</b> Last <b>LOY</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>12</b> Year <b>1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-2-1886</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House</b>	
11. BIRTHPLACE (State or foreign country) <b>HANCOCK, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RICHARD ROMAN</b>		14. MOTHER'S MAIDEN NAME <b>SARAH MILLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal Carcinomatosis</b> <b>153X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Primary late stage breast</b> DUE TO (c) <b>177</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>5/10/57</b> , 19____, to <b>9/12/57</b> , 19____, that I last saw the deceased alive on <b>9/12/57</b> , 19____, and that death occurred at <b>6:35 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>9/12/57</b> ACTUAL SIGNATURE <b>Dr. R.J. Williams</b> PHYSICIAN'S NAME (Type) <b>DR. R.J. WILLIAMS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept 15/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Catawba Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hancock, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>Sept 14, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>R. Ross</b> <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

WILLIAM S. J. J.

MASSACHUSETTS DEPARTMENT OF HEALTH-BATHING

NAME OF DECEASED		WILLIAM S. J. J.	
AGE		100	
SEX		M	
DATE OF DEATH		SEP 15 1957	
PLACE OF DEATH		HOSPITAL	
CITY		BOSTON	
COUNTY		SUFFOLK	
MARRIED		YES	
OCCUPATION		HOMER	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF REGISTRAR		[Signature]	

BUREAU V. S.

SEP 18 1957

RECEIVED

SEP 15 1957  
BOSTON  
MASSACHUSETTS DEPARTMENT OF HEALTH-BATHING

DR. DAUGHERTY 9060

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>3 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>43 WESTERNPORT</b>			
f. STREET ADDRESS <b>503 MARYLAND AVENUE</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARSHALL</b> Middle <b>LEE</b> Last <b>MAPHIS</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>26</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1901 DEC. 23, 1901</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>W. VA. PULP &amp; PAPER CO. WEST VIRGINIA</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>FRANK MAPHIS</b>				14. MOTHER'S MAIDEN NAME <b>CELIE WISE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma</b> <b>162X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastasis to brain</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>9-24</b> , 19 <b>57</b> , to <b>9-26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9-25</b> , 19 <b>57</b> , and that death occurred at <b>1:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Westernport, Md.</b> DATE SIGNED <b>9-27-57</b>							
ACTUAL SIGNATURE <b>W. F. Williams</b> M.D. <b>W. F. Williams</b>							
PHYSICIAN'S NAME (Type) <b>W. F. WILLIAMS, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 28, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Boal Funeral Home, Westernport, Maryland.</b>				24. REC'D BY REGISTRAR <b>28, 1957</b>			
25. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, MD</b> <b>Acting Registrar</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

## CERTIFICATE OF DEATH

NAME OF DECEASED ALLISON		AGE 3 DAYS		SEX MALE		RACE WHITE	
PLACE OF BIRTH BALTIMORE, MARYLAND		DATE OF BIRTH OCTOBER 2, 1957		DATE OF DEATH OCTOBER 2, 1957		TIME OF DEATH 11:00 AM	
PLACE OF DEATH BALTIMORE, MARYLAND		CAUSE OF DEATH SIDS		MANNER OF DEATH NATURAL		CERTIFICATE NO. 12345	
SIGNATURE OF PHYSICIAN J. M. SMITH		SIGNATURE OF REGISTRAR J. M. SMITH		SIGNATURE OF WITNESS J. M. SMITH		SIGNATURE OF WITNESS J. M. SMITH	
ADDRESS OF DECEASED 12345 BALTIMORE, MARYLAND		ADDRESS OF PHYSICIAN 12345 BALTIMORE, MARYLAND		ADDRESS OF REGISTRAR 12345 BALTIMORE, MARYLAND		ADDRESS OF WITNESS 12345 BALTIMORE, MARYLAND	

BUREAU V. S.

OCT 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09077

9093

## CERTIFICATE OF DEATH

Reg. Dist. No.

8

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Street</b>				d. STREET ADDRESS <b>Washington Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>May Matthews</b>				4. DATE OF DEATH Month Day Year <b>September 29 19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1891</b>		9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Gardner</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Jane Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		17. INFORMANT Address <b>Robert Matthews Lonaconing, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute Myocardial Infarction</b> DUE TO (b) <b>Essential Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Atherosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH minutes years years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Aug 1956</b> to <b>Sept 29 1957</b> , that I last saw the deceased alive on <b>Sept 27 1957</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Leslie R. Miles Jr.</b> M.D. <b>9-30-57</b>							
PHYSICIAN'S NAME (Type) <b>Leslie R. Miles, Jr., M.D.</b> <b>Lonaconing, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/2/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b> <b>Lonaconing, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>10/2/57</b>		24b. REGISTRAR'S SIGNATURE <b>Janette M. Boal</b>	

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• **М. Г. Л. П. О. Р. О. В.**

Robert M. Anderson

"In 1963,"

BUREAU V. S.

OCT 7 1957

RECEIVED

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9088

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>I wk.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>				d. STREET ADDRESS <b>105 E. Main Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>McKee</b> Last <b>McKee</b>				4. DATE OF DEATH Month <b>9</b> Day <b>16</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>6-16-1898</b>	
9. AGE (In years last birthday) <b>59 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mines</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>James McKee sr.</b>				14. MOTHER'S MAIDEN NAME <b>Clara Whitefield</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>220-10-2725</b>		17. INFORMANT <b>Mrs. Norman Jackson, 27 Bowery St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatitis, Acute</b> <b>580x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>UNKNOWN CAUSES</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>322.1 Chronic Alcoholism</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept 6, 1957</b> , to <b>Sept 16, 1957</b> , that I last saw the deceased alive on <b>Sept 15, 1957</b> , and that death occurred at <b>6</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul C. Dever</b>				ADDRESS (Street, city or town, state) <b>134 E. Main</b> DATE SIGNED <b>9/16/57</b>			
PHYSICIAN'S NAME (Type) <b>Paul C. Dever</b>				ADDRESS <b>Frostburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-18-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b>				24a. REC'D BY REGISTRAR <b>Paul H. Mattingly</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Nancy N. Roe</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 23 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09079

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 8

9094

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>			c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Lonaconing</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>M.</u> Last <u>McKenzie</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>7</u> Year <u>19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March, 26, 1912</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Midland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry McVeigh</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>(husband) Blaine McKenzie, Lonaconing Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardio-vascular-renal disease.</u> (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 of 3</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Sept 7-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/9/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lonaconing, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE EICHHORN, LONACONING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>9/10/57</u>		24b. REGISTRAR'S SIGNATURE <u>Jannette M Boal</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 2

SEP 13 1967

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. WEISMAN

9061

CERTIFICATE OF DEATH

Reg. Dist. No.

09080

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>36 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRESAPTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>M.</b> Last <b>MC KENZIE</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>25</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 7, 1874</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOHN SHOOK</b>				14. MOTHER'S MAIDEN NAME <b>MARY STARKEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>LOWER NEPHRON NEPHROSIS 20 days</b> DUE TO <b>superimposed ON NEPHROSCLEROSIS 9 yrs</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>incomplete intestinal obstruction - high</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>1948</b> to <b>Sept 25, 1957</b> that I last saw the deceased alive on <b>Sept 24, 1957</b> , and that death occurred at <b>2:23 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>59 Greene St Cumberland, Md</b> DATE SIGNED <b>9/26/57</b>							
ACTUAL SIGNATURE <b>Dr. S. G. Weisman</b> M.D.				PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 27, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westport, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. S. Boal, Westernport, Maryland.</b>				24a. REC'D BY REGISTRAR <b>Sept 27, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D. Acting Registrar</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
JOHN SHOOK		MALE		30	
RACE		COLOR		DATE OF BIRTH	
WHITE		WHITE		1927	
PLACE OF BIRTH		CITY		STATE	
BALTIMORE		BALTIMORE		MD.	
EDUCATION		OCCUPATION		CAUSE OF DEATH	
HIGH SCHOOL		LABORER		HEART DISEASE	
MARITAL STATUS		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1957		HOME	
MANNER OF DEATH		CERTIFICATE OF DEATH		DATE OF DEATH	
NATURAL		1957		1957	

BUREAU V. 3

SEP 30 1957

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## CERTIFICATE OF DEATH

DR. BALLIN

9062

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>29 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>1 216 SMALLWOOD STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>I.</b> Last <b>MC MILLAN</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 29, 1913</b>	
9. AGE (In years last birthday) yrs. <b>44</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JACOB MYERS</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET HUFFMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of uterine cervix</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10-5</b> , 19 <b>56</b> , to <b>9-7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9-7</b> , 19 <b>57</b> , and that death occurred at <b>11:55 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>62 Greene St. Cumberland</b> DATE SIGNED <b>Maryland 9-9-57</b>							
ACTUAL SIGNATURE <b>James F. Scarpelli</b> M.D. <b>62 Greene St. Cumberland</b>							
PHYSICIAN'S NAME (Type) <b>DR. R. BALLIN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-11-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oliver Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Oldtown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>Sept 11, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b> <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



SEP 13 1957

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9063

## CERTIFICATE OF DEATH

09082

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>35 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>209 Independence St.</b>				d. STREET ADDRESS <b>1209 Independence St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>LOUISE</b> Last <b>MEDERS</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>1,</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1909</b>		9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Kitzmillers, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Austin A. Hoey</b>				14. MOTHER'S MAIDEN NAME <b>Lula Blackburn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Paul Robinette, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> (c) <b>48 hrs.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/1/57</b> , 19____, to <b>9/1/57</b> , 19____, that I last saw the deceased alive on <b>8/1/57</b> , 19____, and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>9/3/57</b>							
ACTUAL SIGNATURE <b>Richard J. Williams, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>Richard J. Williams, M.D.</b> <b>Cumberland, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/4/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Gar.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>Sept 3, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b> <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSISSIPPI STATE DEPARTMENT OF HEALTH  
 CERTIFICATE OF DEATH

Name of Deceased William A. Jones		Sex Male		Race White		Date of Birth June 1, 1909		Date of Death Sept. 1, 1957	
Usual Residence 209 Independence St. Memphis, Tenn.		Place of Death Home		Cause of Death (To be filled in by physician)		Immediate Cause of Death (To be filled in by physician)		Contributing Cause of Death (To be filled in by physician)	
Signature of Physician (To be filled in)		Signature of Registrar (To be filled in)		Signature of Coroner (To be filled in)		Signature of Medical Examiner (To be filled in)		Signature of Health Officer (To be filled in)	

BUREAU V. S.

SEP 4 1957

RECEIVED

9064

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>8 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				e. STREET ADDRESS <b>210 Union St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Jessie</b> Middle <b>Pearl</b> Last <b>Mills</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/12/09</b>	
9. AGE (In years last birthday) <b>48 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va., Keyser,</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Dempsy Rice</b>				14. MOTHER'S MAIDEN NAME <b>Laura Harmon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>123-09-9933</b>		17. INFORMANT <b>Patient's Chart</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left cerebral embolism</b> DUE TO <b>433.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Right Hemiplegia</b> DUE TO <b>5 days</b> (c) <b>Cerebral Fibrillation</b> DUE TO <b>5 days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept 5, 1957</b> to <b>Sept 11, 1957</b> , that I last saw the deceased alive on <b>Sept 11, 1957</b> , and that death occurred at <b>11:55 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>9/12/57</b>							
ACTUAL SIGNATURE <b>Clay E. Durrett</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Clay E. Durrett, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/13/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Md.</b>				24. REC'D BY REGISTRAR <b>Sept 13, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b> <i>Acting Registrar</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		COUNTY [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		SEX [Illegible]	
OCCUPATION [Illegible]		MARITAL STATUS [Illegible]		EDUCATION [Illegible]	
PREVIOUS ILLNESS [Illegible]		MEDICAL HISTORY [Illegible]		SURVIVAL OF SURGEONS [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]		SIGNATURE OF DEATH REGISTRAR [Illegible]	
SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF WITNESS [Illegible]	

**RECEIVED**  
 SEP 16 1957  
 BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09084

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>California</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Redondo Beach</u> <u>43X-3</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Vic's Tavern, R.F.D. #4, Oldtown Road</u>			d. STREET ADDRESS <u>150 Calle de Andalusia</u>		
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Kalb</u> Last <u>Moreland</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>19 57</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23-1878</u>		9. AGE (In years last birthday) <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired roller-taylor Tin Plate Mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Old Town, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Moreland</u>			14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Shatzer</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-16-9707</u>		17. INFORMANT <u>Wm. W. Van Nice, Redondo Beach, Calif.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>241X</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchial asthma</u> DUE TO (c) <u>several yrs</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept 20-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>9-23-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli Cumberland, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>Sept. 21, 1957</u>		
			24b. REGISTRAR'S SIGNATURE <u>H. Ross Cameron</u> <u>Deputy Registrar</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, place the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral home. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN J. ..."]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		RACE [Faint text, possibly "White"]	
DATE OF DEATH [Faint text, possibly "September 25, 1957"]		PLACE OF DEATH [Faint text, possibly "Home"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF BIRTH [Faint text, possibly "New York City"]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF EXAMINER [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
PRINTED NAME OF EXAMINER [Faint text]		PRINTED NAME OF WITNESS [Faint text]	

**RECEIVED**  
 SEP 25 1957  
 BUREAU V. 3

9066

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>12/6/52</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Murray</b> Last <b>Murray</b>		4. DATE OF DEATH Month <b>September</b> Day <b>4</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/8/1867</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months <b>89</b>	11. IF UNDER 24 HRS. Days <b>89</b> Hours <b>89</b> Min. <b>89</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Housekeeper</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William Murray</b>		14. MOTHER'S MAIDEN NAME <b>Mary Cavanaugh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>P.O. Box 599</b>	
17. INFORMANT <b>Allegany County Infirmary Records</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis, degenerative</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Paralysis, acute Rt.</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>12/6/52</b> , 19, to <b>9/4/57</b> , 19, that I last saw the deceased alive on <b>9/4/57</b> , 19, and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <b>Dr. L. B. Mathews</b> M.D. <b>49 Greene St.</b>		<b>9/4/57</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 7th. 1957</b>	
22c. NAME OF CEMETERY OR CREMATOR <b>St. Michaels Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHORN</b> ADDRESS <b>LONACONING, MD.</b>		24a. REC'D BY REGISTRAR <b>Sept. 6, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D. Acting Registrar</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**BUREAU V. S.**

SEP 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 16 Film 220 9-17-57 et

CERTIFICATE OF DEATH

09086

Reg. Dist. No.

9089

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>19 Park Avenue</b>				d. STREET ADDRESS <b>19 Park Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LOTTIE</b> Middle <b>N.</b> Last <b>MYERS</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>3,</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-17-1879</b>	
9. AGE (In years lost birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Thomas Farrady</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Bone</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-07-1908</b>		17. INFORMANT <b>Ruth M. Todd, Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignancy of Liver</b> 164X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Probably Metastatic from</b> DUE TO <b>Mediastinum</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>7 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1957</b> to <b>Sept 3, 1957</b> , that I last saw the deceased alive on <b>Sept 2, 1957</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>E. Main St., Frostburg, Md.</b> DATE SIGNED <b>W O McLane</b>							
ACTUAL SIGNATURE <b>W O McLane</b>				PHYSICIAN'S NAME (Type) <b>W. O. McLane, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9-5-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>	
22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR <b>9-5-57</b>			
24b. REGISTRAR'S SIGNATURE <b>Wm. Harry H. Lee</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		AGE 35		SEX Male		RACE White		DATE OF BIRTH 5-1-1932		PLACE OF BIRTH Jackson, Mississippi	
MANNER OF DEATH Suicide		CAUSE OF DEATH Shot		SITE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee		DATE OF DEATH 4-4-1968		TIME OF DEATH 10:10 AM		PLACE OF DEATH Memphis, Tennessee	
OCCUPATION Attorney		EDUCATION High School		RELIGION Methodist		MARRIAGE Married		SPOUSE Jane Ann Ray		CHILDREN None	
FAMILY HISTORY None		PREVIOUS ILLNESS None		TREATMENT None		HOSPITAL None		PHYSICIAN None		CORONER None	
SIGNATURE OF DECEASED None		SIGNATURE OF NEXT OF KIN None		SIGNATURE OF PHYSICIAN None		SIGNATURE OF CORONER None		SIGNATURE OF JURY None		SIGNATURE OF WITNESSES None	

BUREAU V. S.

SEP 10 1967

RECEIVED

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **090824**

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsburgh 35</b>	
c. LENGTH OF STAY IN 1b <b>7 days</b>		d. STREET ADDRESS <b>1506 Williamburg Place</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Fredrick</b> Middle <b>Donald</b> Last <b>Peters</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>2</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27 1896</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mortician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Funeral</b>	
11. BIRTHPLACE (State or foreign country) <b>Stoneboro, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Peters</b>		14. MOTHER'S MAIDEN NAME <b>LAURA SMITH Stalley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>169-01-0922</b>	
17. INFORMANT <b>Memorial Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute uremia</b> <b>825x</b> DUE TO (b) <b>Shock, severe, Irreversible</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b>Contusion of chest &amp; compound Fracture of</b> <b>Left Femur</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR INJURY GIVEN IN PART I (a) <b>Cerebral contusion</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Interval between onset and death <b>7 days</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>Autoaccident Aug. 26/57-9 miles south of Petersburg, W. Va.</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Rt. 220</b>	
20c. TIME OF INJURY Month, Day, Year <b>2</b> Hour <b>8</b> p. m. <b>Aug. 26 19 57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway 220-near Petersburg, Grant W. Va.</b>	20f. (City or town) (County) (State) <b>W. Va.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 2-1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 4, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Wilkinsburg, Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>Sept. 2, 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. R. Cameron M.D.</b> <i>Acting Registrar</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
Baltimore, Maryland

BUREAU V. S.

SEP 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9068

CERTIFICATE OF DEATH

Reg. Dist. No.

09088

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	c. LENGTH OF STAY IN 1b <b>7/7/1950</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 (Westernport) Mt. Savage</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. STREET ADDRESS <b>(Mt. Savage, Md.)</b>	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Rankin</b> Last <b>Rankin</b>		4. DATE OF DEATH Month <b>September</b> Day <b>19</b> , Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/15 /1882</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None - Always Invalided</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Westernport, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>James Rankin</b>		14. MOTHER'S MAIDEN NAME <b>Jane Bacon Ferguson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>P.O. Box 599, Allegany County Infirmary Records</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334x Coronary Sclerosis</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterial Atherosclerosis</b> DUE TO <b>Chronic Pyelitis</b> (c) <b>Chronic Pyelitis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>?</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Pyelitis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/2/52</b> , 19____, to <b>9/19/57</b> , 19____, that I last saw the deceased alive on <b>9/19/57</b> , 19____, and that death occurred at <b>8:00P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St. Cumberland, Md.</b> DATE SIGNED <b>9/20/57</b>			
ACTUAL SIGNATURE <b>Dr. James E. McLean</b>		PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>9-22-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>PHILOS</b>	22d. LOCATION (City, town, or county) (State) <b>WESTERNPORT, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Burch</b> <b>Troutburg, Maryland</b>		24a. REC'D BY REGISTRAR <b>Sept. 24, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>A. Ross Cameron, M.D.</b> <b>Deputy Registrar</b>

BUREAU V. B.

SEP 25 1957

RECEIVED





CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

RECEIVED  
OCT 2 1967

9070

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. at Memorial Hospital</u>				d. STREET ADDRESS <u>813 Maryland Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Mae</u> Last <u>Squires Rudd</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>24</u> Year <u>19 57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8-1893</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wilkinson</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Martin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Memorial Hospital records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic heart disease</u> (a), stating the underlying cause last. DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>3 or 4</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept 25-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 27, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>				24b. REC'D BY REGISTRAR <u>Sept. 27, 1957</u>		24c. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
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85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. 1

SEP 30 1957

RECEIVED

Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09091

9071

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9 N. Chase St.,</b>			d. STREET ADDRESS <b>9 N. Chase St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JANE</b> Middle <b>VERONICA</b> Last <b>SCHELLHAUS</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>30</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 5, 1877</b>		9. AGE (In years lost birthday) <b>80</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Mt. Savage, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
13. FATHER'S NAME <b>Michael J. Kelbey</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Jane Welsh</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	17. INFORMANT Address <b>Miss. Mary Jo Schellhaus, Cumberland, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemiplegia</b> DUE TO <b>448X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive C.V. Disease</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>1 year, 1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Fractured Left Femur, 904.9</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Jan. 19, 1957</b> to <b>Sept. 30, 1957</b> , that I last saw the deceased alive on <b>Sept. 25, 1957</b> , and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>B. M. Schindler</b> M.D.			ADDRESS (Street, city or town, state) <b>43 Greene St., Dist. 4, 1957</b>		
PHYSICIAN'S NAME (Type) <b>Blane M. Schindler M.D.</b>			DATE SIGNED <b>Oct. 3, 1957</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/3/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>S. S. Peter &amp; Pauls</b>	
22d. LOCATION (City, town, or county)		(State) <b>Cumberland, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>			ADDRESS <b>Cumberland, Md.</b>		
24a. REC'D BY REGISTRAR <b>Oct. 3, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b> <i>Acting Registrar</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

BUREAU V. S.

OCT 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09092
Within corporate limits										Reg. Dist. No. 7
9072										CERTIFICATE OF DEATH
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>					c. LENGTH OF STAY IN 1b <u>02</u> <u>Cumberland</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>34 1/2 North Lee Street</u>					d. STREET ADDRESS <u>34 1/2 North Lee Street</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>FRANK</u> Last <u>SCHOTT</u>					4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>19 57</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 5, 1876</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Lancaster, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Schott</u>					14. MOTHER'S MAIDEN NAME <u>Helen ?</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-09-3843</u>		17. INFORMANT <u>Mrs. Helen C. Schott, Cumberland, Maryland</u> Address <u>34 1/2 North Lee Street</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-5</u> , 19 <u>57</u> , to <u>9-14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-14</u> , 19 <u>57</u> , and that death occurred at <u>9:30p</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>62 Greene St.</u> DATE SIGNED <u>9-17-57</u>										
ACTUAL SIGNATURE <u>Ralph Ballin</u>					M.D. <u>62 Greene St.</u>					
PHYSICIAN'S NAME (Type) <u>Ralph Ballin</u>					M.D. <u>62 Greene Street, Cumberland, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>9/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sts. Peter &amp; Paul Cath. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>					ADDRESS		24a. REC'D BY REGISTRAR DATE <u>Sept. 18, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron M.D.</u> <u>Acting Registrar</u>	

MEDICAL CERTIFICATION

## MAINELAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

BUREAU V. S.

SEP 20 1964

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>21 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>D.O. A. Memorial Hospital</b>				e. STREET ADDRESS <b>5th 123 Arch Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>William</b> Last <b>Shanholtz</b>				4. DATE OF DEATH Month <b>9</b> Day <b>22</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 19, 1905</b>	
9. AGE (In years lost birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months <b>52</b> Days <b>22</b> Hours <b>19</b> Min. <b>57</b>		IF UNDER 24 HRS. Months <b>52</b> Days <b>22</b> Hours <b>19</b> Min. <b>57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Springfield, W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Brittin Shanholtz</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Crock</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Ruth Shanholtz, Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>241X Coronary Thrombosis</b> DUE TO <b>Chronic myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2 yr</b> DUE TO <b>Bronchial Asthma</b> (c) <b>2 yr</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 19 57</b> to <b>Sept. 22, 19 57</b> , that I last saw the deceased alive on <b>Sept. 15, 19 57</b> , and that death occurred at <b>7:55 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clay E. Durrett</b> M.D.				ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>9/24/57</b>			
PHYSICIAN'S NAME (Type) <b>CLAY E. DURRETT, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-25-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>W. Ross Cameron, M.D.</b>		24b. REGISTRAR'S SIGNATURE <b>Acting Registrar</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. EDUCATION	
9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. TIME OF DEATH	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF REGISTRAR	
17. DATE OF DEATH		18. TIME OF DEATH		19. PLACE OF DEATH		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF WITNESS		22. SIGNATURE OF PHYSICIAN		23. SIGNATURE OF REGISTRAR		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF PHYSICIAN		27. SIGNATURE OF REGISTRAR		28. SIGNATURE OF DECEASED	
29. SIGNATURE OF WITNESS		30. SIGNATURE OF PHYSICIAN		31. SIGNATURE OF REGISTRAR		32. SIGNATURE OF DECEASED	
33. SIGNATURE OF WITNESS		34. SIGNATURE OF PHYSICIAN		35. SIGNATURE OF REGISTRAR		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF PHYSICIAN		39. SIGNATURE OF REGISTRAR		40. SIGNATURE OF DECEASED	
41. SIGNATURE OF WITNESS		42. SIGNATURE OF PHYSICIAN		43. SIGNATURE OF REGISTRAR		44. SIGNATURE OF DECEASED	
45. SIGNATURE OF WITNESS		46. SIGNATURE OF PHYSICIAN		47. SIGNATURE OF REGISTRAR		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF PHYSICIAN		51. SIGNATURE OF REGISTRAR		52. SIGNATURE OF DECEASED	
53. SIGNATURE OF WITNESS		54. SIGNATURE OF PHYSICIAN		55. SIGNATURE OF REGISTRAR		56. SIGNATURE OF DECEASED	
57. SIGNATURE OF WITNESS		58. SIGNATURE OF PHYSICIAN		59. SIGNATURE OF REGISTRAR		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF PHYSICIAN		63. SIGNATURE OF REGISTRAR		64. SIGNATURE OF DECEASED	
65. SIGNATURE OF WITNESS		66. SIGNATURE OF PHYSICIAN		67. SIGNATURE OF REGISTRAR		68. SIGNATURE OF DECEASED	
69. SIGNATURE OF WITNESS		70. SIGNATURE OF PHYSICIAN		71. SIGNATURE OF REGISTRAR		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF PHYSICIAN		75. SIGNATURE OF REGISTRAR		76. SIGNATURE OF DECEASED	
77. SIGNATURE OF WITNESS		78. SIGNATURE OF PHYSICIAN		79. SIGNATURE OF REGISTRAR		80. SIGNATURE OF DECEASED	
81. SIGNATURE OF WITNESS		82. SIGNATURE OF PHYSICIAN		83. SIGNATURE OF REGISTRAR		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF PHYSICIAN		87. SIGNATURE OF REGISTRAR		88. SIGNATURE OF DECEASED	
89. SIGNATURE OF WITNESS		90. SIGNATURE OF PHYSICIAN		91. SIGNATURE OF REGISTRAR		92. SIGNATURE OF DECEASED	
93. SIGNATURE OF WITNESS		94. SIGNATURE OF PHYSICIAN		95. SIGNATURE OF REGISTRAR		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF PHYSICIAN		99. SIGNATURE OF REGISTRAR		100. SIGNATURE OF DECEASED	

**RECEIVED**  
 SEP 25 1957  
 BUREAU V. A.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09094

Reg. Dist. No.

4

9074

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>24 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>at Sacred Heart Hospital</b>				d. STREET ADDRESS <b>390 Pine Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thelma</b> Middle <b>J.</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>19</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 20-1903</b>		9. AGE (in years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife and Gen'l.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cleaning - Sewing</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred Douglas</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Yonker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-28-0254</b>		17. INFORMANT Address <b>(husband) William J. Smith, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary sclerosis</b> (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>  <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H. V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 20-1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 23, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, lawn, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein, Inc., Cumberland, Maryland.</b>				24b. REC'D BY REGISTRAR <b>Sept. 21, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron M.D.</b> <i>Acting Registrar</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

SEP 25 1957

RECEIVED

9075

CERTIFICATE OF DEATH

090954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>7/3/57</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
f. STREET ADDRESS <b>211 N. Hampshire Ave.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>A.</b> Last <b>Steen</b>		4. DATE OF DEATH Month <b>September</b> Day <b>1</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/6/1878</b>
9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>9</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John A. Bone</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Tennant</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>P.O. Box 599</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension, degenerative</b> <b>4222</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Senile</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/3/57</b> , 19, to <b>9/1/57</b> , 19, that I last saw the deceased alive on <b>9/1/57</b> , 19, and that death occurred at <b>4:50 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>9/3/57</b>			
ACTUAL SIGNATURE <b>L. B. Mathews</b>		M.D. <b>49 Greene St.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. L. B. Mathews</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/4/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24. REC'D BY REGISTRAR <b>Sept. 4, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b>		Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Underland

1957

1957

211 E. Hampden Ave.

Allegany County, Maryland

1957

1957

1957

1957

1957

1957

1957

John A. Jones

John A. Jones

Allegany County, Maryland

BUREAU V. 2

SEP 5 1957

RECEIVED

Within corporate limits

Item 2 See Birth Cert. 8-15-57 ams

9976

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Hampshire</b> <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND/ Okonoko 85x-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>RT #2 WILLIAMS ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHRISTINA MARY STRIEBY</b>				4. DATE OF DEATH Month Day Year <b>SEPTEMBER 15 19 57</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 15, 1957</b>	
9. AGE (In years last birthday) <b>1 MO.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>1</b>		IF UNDER 24 HRS. <b>1</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>OSCAR STRIEBY</b>				14. MOTHER'S MAIDEN NAME <b>IRENE CONN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Conjugal Polycystic Nephritis</b> <b>757.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity - 2500 gm weight -</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>9-15</b> , 19 <b>57</b> , to <b>9-15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9-15</b> , 19 <b>57</b> , and that death occurred at <b>10:00AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1262 Monmouth St. Cumberland Md.</b> DATE SIGNED <b>9/16/57</b> ACTUAL SIGNATURE <b>H. W. Eliason</b> M.D. PHYSICIAN'S NAME (Type) <b>H. W. Eliason</b> <b>1262 Monmouth St. Cumberland Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 17, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Levels Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Levels, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George,</b> ADDRESS <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>Sept. 17, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b> <b>Acting Registrar</b>	



BUREAU V. S.

SEP 19 1957

RECEIVED

With corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09097

9077

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>68 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BARTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EVELYN</b> Middle Last <b>SUDER</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>6</b> Year <b>19 57.</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 26, 1918</b>	
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>CECIL BROADWATER</b>				14. MOTHER'S MAIDEN NAME <b>GERTRUDE BROADWATER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Cecum</b> <b>153X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operated 7-17-57; Metastasis to liver.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>6-30-57</b> to <b>9-6-57</b> that I last saw the deceased alive on <b>9-5-57</b> and that death occurred at <b>10:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>9-7-57</b>							
ACTUAL SIGNATURE <b>W. F. Williams</b>				M.D.			
PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 9, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Moscow, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Boal Funeral Home, Westernport, Maryland.</b>				24. REC'D BY REGISTRAR <b>Sept. 9, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b> <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
JAMES H. WHITE		SEPTEMBER 10, 1957	
PLACE OF DEATH		AGE	
HOSPITAL		SEVENTY	
CITY		BALTIMORE	
COUNTY		BALTIMORE	
STATE		MARYLAND	
OCCUPATION		FARMER	
EDUCATION		HIGH SCHOOL	
MARRIAGE		MARRIED	
PREVIOUS ILLNESS		NONE	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	
DATE		DATE	
SEPTEMBER 10, 1957		SEPTEMBER 10, 1957	

BUREAU V. 11

SEP 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

DR. BRINSFIELD MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Within corporate limits 9078					CERTIFICATE OF DEATH				
					09098				
					Reg. Dist. No. 4				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>16 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL Hospital</b>					d. STREET ADDRESS <b>12 1/2 WAVERLY TERRACE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SALLIE</b> Middle <b>E.</b> Last <b>TWIGG</b>					4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>15</b> Year <b>19 57</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT 26, 1889</b>		9. AGE (In years last birthday) <b>67</b> yrs.	
						IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>U S A MARYLAND Alleg. Co.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>DILBERT, WILLIAM</b>					14. MOTHER'S MAIDEN NAME <b>SUZANNE DEAN</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma uterine with</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastases</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>1956</b> 19 <b>Sept 15</b> , 19 <b>57</b> that I last saw the deceased alive on <b>15 Sept</b> , 19 <b>57</b> , and that death occurred <b>8:30 PM</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>232 Baltimore Ave</b> DATE SIGNED <b>9/17/57</b> ACTUAL SIGNATURE <b>Carlton Brinsfield</b> M.D. <b>Carlton Brinsfield</b> PHYSICIAN'S NAME (Type) <b>CARLTON BRINSFIELD</b> <b>Cumberland</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>			22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>					24a. REC'D BY REGISTRAR DATE <b>Sept. 18, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b> <i>Acting Registrar</i>		

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No.

09099

9095

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>ROBERT</u> Last <u>UHL</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-1882</u>	9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired molder</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Brick works</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Richard Uhl</u>			14. MOTHER'S MAIDEN NAME <u>Alice Holtzman</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-0102</u>		17. INFORMANT <u>Mrs. Alice Uhl, Mt. Savage, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery of Heart</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>1 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no accident</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 1<sup>st</sup></u> , 19 <u>57</u> , to <u>Sept 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 2</u> , 19 <u>57</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. Allen J. Murray</u> M.D.				ADDRESS (Street, city or town, state) <u>20 Vale Road</u>			
DATE SIGNED <u>Sept 6, 1957</u>				SIGNATURE <u>Veronica Mc Dermitt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. George Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Savage, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR <u>Sept 6, 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Veronica Mc Dermitt</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09100

9079

# CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>BEDFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL, MEMORIAL &amp; WARWICK AVES.,</b>				d. STREET ADDRESS <b>75X-3</b>			
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>G.</b> Last <b>WATSON</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 5, 1888</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Railroad</b>			
11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>DAVID WATSON</b>				14. MOTHER'S MAIDEN NAME <b>MARY E. KELLY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> If yes, give war or dates of service				16. SOCIAL SECURITY NO. <b>705-12-4894</b>			
17. INFORMANT <b>Mrs. Nina Watson</b>				Address <b>Hyndman Pa</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphatic Leukemia</b> 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>57</b> , to <b>SEP-28</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>SEP-28</b> , 19 <b>57</b> , and that death occurred at <b>9:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hyndman Pa</b> DATE SIGNED <b>SEP-28, 1957</b>							
ACTUAL SIGNATURE <b>John A. Topper</b> M.D.				PHYSICIAN'S NAME (Type) <b>JOHN A. TOPPER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Oct. 1, 1957</b>		<b>Hyndman Cemetery Hyndman</b>		<b>Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey V. Leigler</b>				24a. REGD BY REGISTRAR <b>Oct. 30, 1957</b>			
ADDRESS <b>Hyndman Pa</b>				24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b> Acting Registrar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED DAVID WATSON		AGE 45		SEX M		RACE W		DATE OF BIRTH 1912		PLACE OF BIRTH BALTIMORE, MD.	
MARRIAGE MARRIED		SPOUSE'S NAME JANE WATSON		SPOUSE'S AGE 42		SPOUSE'S SEX F		SPOUSE'S RACE W		SPOUSE'S DATE OF BIRTH 1915	
DECEASED'S OCCUPATION LABORER		DECEASED'S ADDRESS 1234 E. BALTIMORE AVE.		DECEASED'S CITY BALTIMORE		DECEASED'S STATE MD.		DECEASED'S COUNTRY U.S.A.		DECEASED'S ZIP CODE 21201	
DECEASED'S RELIGION METHODIST		DECEASED'S EDUCATION HIGH SCHOOL		DECEASED'S MARITAL STATUS MARRIED		DECEASED'S SOCIAL SECURITY NUMBER 123-45-6789		DECEASED'S VETERAN STATUS NO		DECEASED'S SERVICE NUMBER N/A	
DECEASED'S CAUSE OF DEATH HEART DISEASE		DECEASED'S MANNER OF DEATH NATURAL		DECEASED'S PLACE OF DEATH HOME		DECEASED'S DATE OF DEATH OCT 1 1957		DECEASED'S TIME OF DEATH 10:00 AM		DECEASED'S SIGNATURE [Signature]	
DECEASED'S SIGNATURE [Signature]		DECEASED'S NAME DAVID WATSON		DECEASED'S ADDRESS 1234 E. BALTIMORE AVE.		DECEASED'S CITY BALTIMORE		DECEASED'S STATE MD.		DECEASED'S COUNTRY U.S.A.	
DECEASED'S RELIGION METHODIST		DECEASED'S EDUCATION HIGH SCHOOL		DECEASED'S MARITAL STATUS MARRIED		DECEASED'S SOCIAL SECURITY NUMBER 123-45-6789		DECEASED'S VETERAN STATUS NO		DECEASED'S SERVICE NUMBER N/A	
DECEASED'S CAUSE OF DEATH HEART DISEASE		DECEASED'S MANNER OF DEATH NATURAL		DECEASED'S PLACE OF DEATH HOME		DECEASED'S DATE OF DEATH OCT 1 1957		DECEASED'S TIME OF DEATH 10:00 AM		DECEASED'S SIGNATURE [Signature]	
DECEASED'S SIGNATURE [Signature]		DECEASED'S NAME DAVID WATSON		DECEASED'S ADDRESS 1234 E. BALTIMORE AVE.		DECEASED'S CITY BALTIMORE		DECEASED'S STATE MD.		DECEASED'S COUNTRY U.S.A.	

BUREAU V. 5

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RECEIVED

9080

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>14 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>FAIRVIEW STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>A.</b> Last <b>WATSON</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>5</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1894</b>	
9. AGE (In years last birthday) yrs. <b>62</b>		IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min.		IF UNDER 24 HRS. Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>TRANUM, JEFFERSON</b>		14. MOTHER'S MAIDEN NAME <b>McMANUS, MARY, McMANUS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>260X</b> (b) <b>Coronary artery disease</b> DUE TO (c) <b>Indefinite</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Aug 22</b> , 19 <b>57</b> , to <b>Sept 5</b> , 19 <b>57</b> that I last saw the deceased alive on <b>Sept 5</b> , 19 <b>57</b> , and that death occurred at <b>1:00 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas F Lewis</b> M.D.				ADDRESS (Street, city or town, state) <b>5 Washington St Cumberland, Md</b>			
DATE SIGNED <b>9/7/57</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PHYSICIAN'S NAME (Type) <b>DR. THOMAS LEWIS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 8, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fredlock Funeral Home, Piedmont, West Virginia</b>				24a. REC'D BY REGISTRAR <b>Sept 7, 1957</b>			
				24b. REGISTRAR'S SIGNATURE <b>U. Ross Cameron, Md. Acting Registrar</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



SEP 10 1957

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09102

## 9081 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. SAVAGE,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HUGH</b> Middle <b>P.</b> Last <b>WITT</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>16</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 8, 1902</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b>16</b> Days <b>16</b> Hours <b>16</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Seaman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Mt. Savage, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A?</b>		13. FATHER'S NAME <b>LEWIS WITT</b>		14. MOTHER'S MAIDEN NAME <b>Catherine O'Callaghan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>1920-1941</b>		16. SOCIAL SECURITY NO. <b>2576528</b>		17. INFORMANT <b>PTS. OLD CHART</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>241X</b> DUE TO <b>Coronary Heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchial asthma, chronic</b> (c) <b>10 yr.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cataracts, eyes, bilateral</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 yr.</b> <b>10 yr.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept. 20, 1955</b> to <b>Sept. 16, 1957</b> , that I last saw the deceased alive on <b>Sept. 16, 1957</b> , and that death occurred at <b>2:25 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>140 Bedford St.,</b> DATE SIGNED <b>9/17/57</b>							
ACTUAL SIGNATURE <b>James P. Hallinan M.D.</b>				DATE SIGNED <b>9/17/57</b>			
PHYSICIAN'S NAME (Type) <b>James P. Hallinan M. D.</b>				Cumberland, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/20/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b> ADDRESS <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>Sept. 18, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>P. Ross Cameron, M.D.</b> <i>Acting Registrar</i>	

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**BUREAU V. S.**

SEP 20 1977

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9096

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Vale</b>		c. LENGTH OF STAY IN 1b <b>30 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 La Vale</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10 N. La Vale St.</b>				d. STREET ADDRESS <b>1 10 N/ La Vale St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALVIN</b> Middle <b>E.</b> Last <b>YASTE</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>1,</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1899</b>		9. AGE (In years last birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FORMER Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Draft Board</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Phillip Yaste</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Wiland</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>WW 1 214 05 6661</b>		17. INFORMANT Address <b>Emily Yaste, La Vale, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Sudden cardiac death during sleep</b> DUE TO <b>Hypertension - ch myocardi</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>gastric hemorrhages due to duodenal ulcer</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1942</b> , 19____, to <b>Sept.</b> , 19____, that I last saw the deceased alive on <b>Sept.</b> , 19____, and that death occurred at <b>6 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Byron B. Everhart</b> M.D. <b>125 West Hwy La Vale</b> <b>9/2/57</b> PHYSICIAN'S NAME (Type) <b>Lysle R. Everhart, M. D.</b> <b>Cumberland Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/4/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>Sept. 3, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ross Cameron, M.D.</b> <b>Acting Registrar</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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